IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MISSOURI

THE UNITED STATES OF AMERICA, *ex rel.*, DR. CHARLES RASMUSSEN, D.O.	)	
Plaintiffs,	)	
v.	)	**Civil No.**
ESSENCE GROUP HOLDINGS CORPORATION, ESSENCE HEALTHCARE, INC., LUMERIS SOLUTIONS COMPANY, LLC, LUMERIS HEALTHCARE OUTCOMES, LLC, AND LESTER E. COX MEDICAL CENTERS	)	**JURY TRIAL DEMANDED**
Defendants.	)	

FILED UNDER SEAL

For its complaint, the United States of America ex rel. Dr. Charles Rasmussen, D.O., (hereinafter "United States"), alleges as follows:

I. Intro

1. This is an action to recover damages and civil penalties on behalf of the United States under the Federal False Claims Act, 31 U.S.C. §§ 3729-31 (hereinafter "FCA") and §§ 375.991-.994, RSMo 2017, against Essence Group Holdings Corp., Essence Healthcare, Inc., Lumeris Solutions Company, LLC, and Lumeris Healthcare Outcomes, LLC., and Lester E. Cox Medical Centers.

II. PARTIES

2. *Qui Tam* plaintiff, Dr. Charles Rasmussen, D.O., (hereinafter "Relator"), is a resident of Branson, Missouri and an employee of Defendant Lester E. Cox Medical Centers. Relator was hired by Cox in 2013 as a physician and he has continued his employment with Cox through August 2017, wherein his employment was ceased and his privileges were suspended for his refusal to comply with defendants' fraudulent billing practices, including, but not limited to, his refusal to order needless exams, diagnoses, and procedures dictated by defendants that were not medically necessary.
3. Relator currently has between 2-3,000 patients that are part of the CoxHealth MedicarePlus program. Thus, Relator has first-hand knowledge and experience with how Lester E. Cox Medical Center cared for its Medicare patients before and after the implementation of the CoxHealth MedicarePlus program.
4. The real party, on whose behalf Relator brings this suit, is the United States. The United States has ongoing contracts with Defendant Essence Healthcare, Inc. through the Centers for Medicare and Medicaid Services of the Department of Health and Human Services, in

accordance with Essence's participation in a Medicare Advantage program. The State of Missouri has recently made effective a statute scheme that makes the practices by Essence unlawful, in that the scheme requires doctors to upcode and unbundle diagnoses to falsely elevate risk adjustment factor scores, as described below.

5. Essence Group Holdings Corp. is a Delaware Corporation that was created in 2007. Essence Group Holdings has two primary, wholly owned, subsidiaries: 1) Essence Healthcare; and 2) Lumeris.

6. Essence Healthcare, Inc. (hereinafter "Essence") operates a private managed care organization covering health insurance benefits for Medicare beneficiaries, pursuant to a contract with the Centers for Medicare and Medicaid Services ("CMS"), the federal agency that administers Medicare. The Medicare Advantage ("MA") program, through which Essence offers its health plans, is designed to apply to Medicare a form of the "managed care" model commonly used by private health insurance companies. Under this model, rather than paying for individual services one at a time as they are delivered to beneficiaries, the managed care organization pays a fixed amount each month for every "member" of the plan—commonly called a monthly "capitation" payment. The entity receiving this capitation payment (often a hospital, physician group, or another health insurance company) is responsible for paying hospitals, physicians and all other medical providers for health care services provided to a member of the plan.

7. Lumeris Solutions Company, LLC, and Lumeris Healthcare Outcomes, LLC, are data service companies that couple with the MA program provided by Essence and data mine patient records wherever Essence's MA program has been implemented. The purpose of this data mining is to further enhance the "Risk Adjustment Factor" ("RAF") score of patients. An RAF score is the basis for the capitation payment and the greater an RAF score, the more money is

provided in monthly capitation payments. The basic scheme is to upcode patients with needless diagnoses to falsely enhance the RAF score, and thereby receive millions of dollars more from CMS.

8. Lester E. Cox Medical Centers ("Cox") is a Nonprofit Corporation organized under the laws of Missouri. Cox partnered with Essence and Lumeris to create CoxHealth MedicarePlus (hereinafter "MedicarePlus"), the MA program that is the subject of this suit. Thus, Cox uses its network of healthcare providers to provide the basis for the RAF score and the capitation rates that Essence should then distribute these capitation payments to Cox as they are needed by the patients. Cox pressures its physicians, terminates its physicians, and retaliates against its physicians, if they refuse to comply with the upcoding billing scheme.

III. BACKGROUND

9. Upon information and belief, Essence entered into a contract with CMS to operate MA plans in 2004 and that contract, following annual renewals, remains ongoing—and has greatly expanded since that time. In each year of its existence, the vast majority of its total revenue—perhaps as much as 100%—is derived from Medicare capitation payments. Essence currently boasts enrollment of more than 60,000 members in its plans.

10. Through the MA program, Medicare allows private health insurers to set up managed care plans to cover Medicare beneficiaries. Medicare pays a monthly capitation rate for each beneficiary enrolled as a member of the MA plan based on an RAF score. MA plans must then use that money to pay hospitals, physicians, and other health care providers for services the members receive.

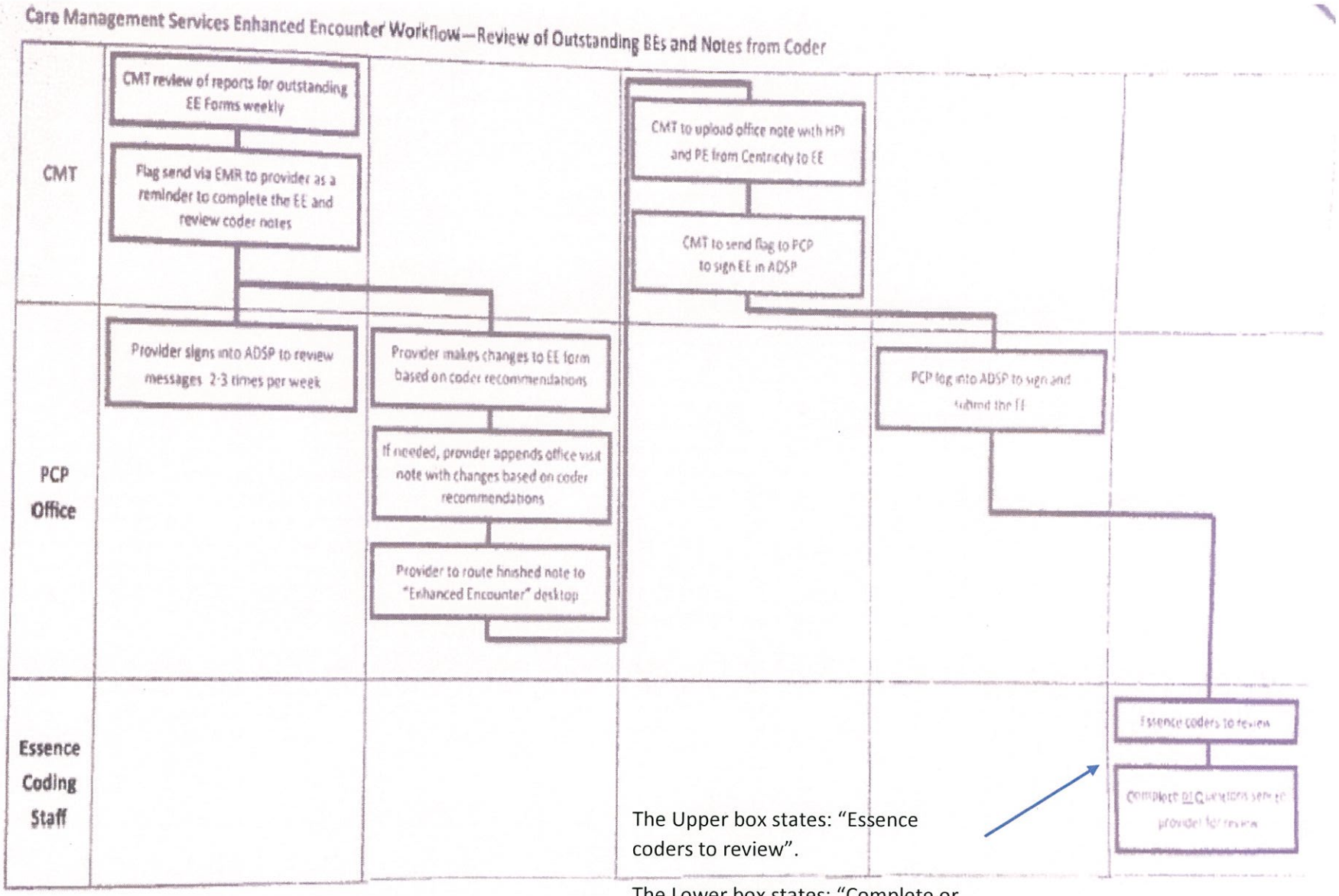
11. Strict rules govern the management of MA plans to ensure that the Medicare beneficiaries receive the heath care they need, and that the Federal government does not overpay for these

services. Defendants have consistently, and fraudulently, violated these program rules to increase profits. Because of this fraud, hundreds of millions of taxpayers' dollars have been siphoned from the United States.

12. Beginning in 2015, Cox, Essence, and Lumeris began collaborating to further expand the reach of this fraudulent scheme. Prior to this time, Cox had provided services to Medicare patients based on the physician's judgment for the well-being of her patient. This practice changed the moment Essence and Lumeris partnered with Cox to create the MedicarePlus program.

13. After the MedicarePlus program's creation and implementation several things changed in how Cox required its physicians to treat its Essence patients, primarily, patients were to be labeled as a higher risk score and physicians were ordered to conduct unnecessary "enhanced encounter" exams to drum up the risk score. It should be noted that Cox expressly tells its physicians to follow a vastly different treatment paradigm for Medicare patients versus Essence patients. The Defendants entire incentive is to falsely drum up risk scores for the Essence patients, which are not done for the normal Medicare patients. Indeed, Cox does not pressure its physicians to order "Enhanced Encounters" or create unnecessary diagnosis for normal Medicare patients, only MedicarePlus patients.

14. The following flow chart shows how MedicarePlus patients would now be provided service:



The Upper box states: "Essence coders to review".

The Lower box states: "Complete or Questions sent to provider for review".

15. The following email was sent by a Cox physician that believed this "scheme" was a blatant attempt to overbill and had nothing to do with the health and well-being of his patients:

I am writing to get some clarification about the Essence meeting we had at lunch today. I feel that since my patient was highlighted as an "opportunity" I can ask for clarification as to my role in this whole process. As I did during the meeting today, I am again asking for clarity here. This is what I understood to be the crux of the meeting—and my partners can all attest to this: I understood that I am being asked to attend webinars that will take 90 minutes about "Enhanced Encounter Training". At this meeting I am going to be advised on how I am to code in an "enhanced" way. I will then be required to see certain patients in my patient panel that have been specifically identified as "opportunities" for Essence. These patients are going to be asked to come, in many cases, back to clinic even though they have already had

a yearly visit so they can have an "enhanced encounter". At this "enhanced encounter" we are supposed to code the visit in a way and fill out a paper form so as to exact as much money as possible from Medicare that will then go to Essence. Essence will then allocate this money in some way of which I have no idea. I was also told that to increase my "PMPM" I would have to do this coding training but was not told what percentage of this money would actually come to me. This expectation and the way it was explained came across poorly. It came across as being told to jump through hoops—not for how to be a good doctor, but for how to code in an "enhanced" way, to be paid money for a job I already signed a contract for with Cox many years ago. I was not aware that I am now working for Essence directly and Essence is now dictating how I am spending my time away from clinic. Adding up the 90 minutes this is supposed to require in addition to the 45 minutes I've spent on the other coding training I've done, we're now getting up to over 2 hours of time I'm supposed to spend (at this point) just to do what Essence is telling me to do to get paid.

Is this all correct at this point or am I missing something?

So this brings me back to my "opportunity" patient. To avoid getting dinged on HIPAA issues I'll refer to him as MF. This is a patient I've seen since October of 2007. At that time his A1c was at 7.9, went up to 9.2, and is now at 6.7 on his last check. He is now 86 years old and "on paper" seems very sick. However, he was not hospitalized once in 2014, prior to his being on the Essence plan. I saw him twice in this time period in 5/2014 and 11/2014 and coded a 99214 and 99213 respectively. I drew an A1c x 2 and lipids x 1. So MCR may have paid less than $200 for my services. He saw urology once (99212), cardiology 3 times (all 99213), ortho once for FU from hip fracture suffered in Kansas (99212), nephrology once (99213 with many labs), dermatology 3 times (99213). Interestingly, none of these visits were acute or resulted in an ER visit or hospitalization. Someone smarter than me in math can run the numbers but MCR may have had less than $2000 out in office visits. However, the executive from Essence today informed me and everyone else in the room that, if coded in an "enhanced" way, there is the "opportunity" to capture around $11,000 from Medicare on MF. Since I know he is pretty healthy for looking sick on paper I asked him to clarify. I asked something to this effect, "If we are trying to keep

healthcare costs down in this country, then why are you asking me to charge Medicare/ the government as much as I can for this patient's care".....and this is all just based on coding. He brought up the example of coding for a toe amputation even if it occurred many years ago. His response was basically that doing this will all work out better for everyone in the end and the doctors in St Louis think it's great!

As you both can imagine, this is all very troubling. What I am needing help with is clarity on how this is ethical. MF's care came nowhere close to $11000 last year, but he has been identified as an "opportunity" for Essence to "capture" this money based only on how things are coded, not on actual care needed or rendered. I realize that I was informed last Friday that some in our organization went into medicine to make as much money as they can for as little work as possible. I have been bothered by this statement all weekend (especially since this is the second time I've heard this). I can say for certain that no physician at CFMA went into medicine for this reason. If we had gone into medicine for this reason, we wouldn't be in primary care. Trust me. So now it seems that we as family physicians are being required to do the bidding for Essence to code in an "enhanced" way, otherwise known as upcoding, to pad their bottom line. We are being made to do the bidding for people who apparently did get into healthcare to make as much money as possible for as little work as possible (telling us to code in an "enhanced way"). This isn't why I went into medicine. All I have heard about since we signed on with Essence is about coding to get paid more. This is doing little to enhance these patients' care.

Please tell me where I am wrong on this. I realize I have a tendency to wear my emotions on my sleeve, but I can be redirected if I'm viewing something in the wrong way. However, I feel like I am being

asked (if not required) to do something that, at this point, I find highly questionable if not unethical. I felt like I needed to take a shower after today's meeting. If I am viewing this wrong then the executive from Essence should have explained it better when I asked him to clarify. Instead, I feel like I am being asked to try to scam the system. A little clarity would be appreciated.

Thanks

16. The following response to the physician's inquiry was provided by a member of Cox's Executive Staff:

I can understand your concern, particularly as related to this particular patient. At his age, it should be considered quite a success for him to stay out of the hospital and not incur more total healthcare cost than he has. Like you, I'm surprised that this patient was identified as such an "opportunity", so I don't feel I can really address that adequately.

The rate of change in healthcare reimbursement models has been rapid recently, and it's just getting started. Many observers believe that we will reach the "tipping point" within the next few years-going from mostly fee-for-service to mostly managed care. Already, the head of CMS has publicly stated that the majority of Medicare dollars will be not be in fee-for-service by 2018. This sweeping change has proven very challenging for both physicians and administrators to get our heads around. (A little more so for physicians in my experience thus far-administrative people sit around trying to understand these things, whereas physicians have better things to do.)
The concept of "care gaps" is fairly new and is, understandably, somewhat offensive to many physicians. Nevertheless, it seems here to stay, at least until the next "new thing" comes along. A couple of things which might not be that visible to physicians yet:

1. Most insurance companies, not just Essence, are establishing programs in which they (not us) identify these care gaps, and pay us more or less based on how well we do closing these. Already CoxHealth physicians are beginning to receive requests from UHC, the Blues, Anthem, and others to close care gaps identified from their claims databases.
2. CoxHealth has less control over this than you might imagine. We are, for the most part, on the receiving end of this and have millions of dollars at stake, based on our performance across a range of quality metrics. In some cases (diabetic eye exams, for example), we do poorly compared to the established benchmarks, and that will cost us.

I look forward to talking with all of you more about this. The next few years will be very challenging, I believe, for many in healthcare, but especially for physicians. We are fortunate enough to work in a very well-run and forward looking healthcare system. It's not perfect, of course, but like all others at this point in time, scrambling to keep up. The bigger changes, the ones which will affect us most, are in the macro-environment. Don't hesitate to let me know how you think I can help you. That's what I'm here for. Thanks!

17. Another of the Executive members at Cox outlined the importance of Enhanced Encounters to "build" an RAF score for members of its MA plan:

Hi Dr. Smith—

I am going to see if I can get some more specifics, but I will tell you what I know right now on how they choose which patients need the Enhanced Encounter forms. Plus I have actually started several so I can tell you different things that I have noticed so far. I have included Dr. Flax because she is much more familiar with all of the details.

Enhanced Encounters really assist us to make sure we are building Risk Adjustment Factors for each of our patients. Depending on specific information documented for patients, the EE system is able to help ask additional questions to make sure we have the best documentation and coding we can have to support the RAF score for each patient. The documentation and review of conditions this year will affect the amount of money allotted to patients for their care for next year. Since most of the patients on CoxHealth Medicare Plus have already been seen in the first 6 months of this year, the EE process will allow for any additional information to be caught and documented.

One of the first ways that patients are identified is based on potential for diagnoses that could be coded to a greater specificity. This seems to most often occur with diabetes and comorbidities, but really any condition may be included. Those conditions with higher HCCs will most often be included. In some of these cases these conditions may have been reviewed already this year, but they have questions to see if there might be other complications that have not been fully documented.

The next thing that they include are conditions that have been billed in the past, but they have not received a claim on yet. When the plan started they received lists of past claims that patients may have had, and for those conditions to affect RAF scores they must be reviewed each year. Some patients just have a couple conditions, but others have had quite a few. It is a way for each of those conditions to be submitted in one document, and will have a positive effect on the RAF.

They are also sometimes looking for additional test results for different conditions. They sometimes want the actual lab information. This is part of what the Care Management Team will complete as part of the form.

The EE form itself will include all specific information based on billing, gender, age, lab results, etc. The form components actually change based on what is entered in the form. There are multiple areas of the form itself that the CMT can complete for you based on visits that have already taken place this year. We are also able to load your actual note into the EE system, which will account for the HPI and Physical Exam. The main area that the provider is responsible for is the assessment and plan. The other areas of the form will be completed by the CMT after the visit based on your office note.

I hope this helped some, and I will definitely get you more information. Please let me know if you have any other questions.

Thank you,

18. These communications, between a Cox physician and Executive Staff at Cox show the incentive for Cox in participating with Essence's scheme: "We are, for the most part, on the receiving end of this and have millions of dollars at stake, based on our performance across a range of quality metrics."

19. While, Cox's Administrative staff show they are just in this for the money, the response provided by a member of Essence's staff shows how that money is to be made:

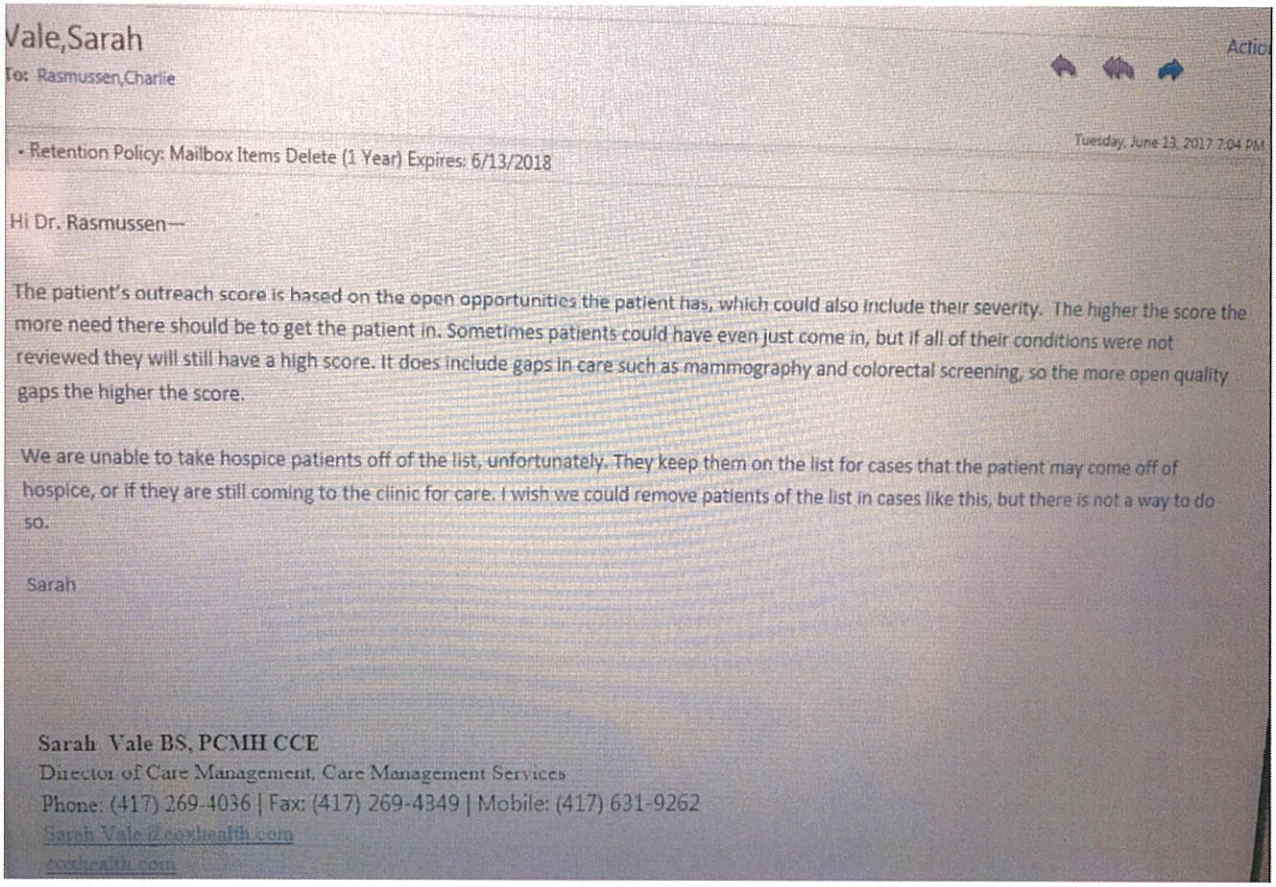
I'm not sure if [redacted] will be able to attend one of our webinars, where we briefly talk about the stratification process. Here is some information which may be helpful.

We run proprietary logic algorithms to identify high-risk members who may have opportunities to improve documentation, coding, and/or coordination of care. Each suspected opportunity is assigned a different risk weight. Examples of opportunities and their weighting include some of the following:

- Patients who have important chronic medical conditions that have not been addressed during the current calendar year or when their last PCP visit was.
- Patients who could benefit from appropriate screening for common high-risk conditions.
- Patients who have multiple quality-related gaps (e.g., patients who have elevated A1C levels and recent non-adherence to their diabetes medications; timing of the fill rate of their medication; etc).

Please let me know if you have any further questions.
Thanks.
Cheri

20. Additionally, the greed of this operation becomes blatantly obvious when Relator inquired into why hospice patients are not taken off the Enhanced Encounter "list." Cox executives provided the following response:



Vale,Sarah

To: Rasmussen,Charlie

Tuesday, June 13, 2017 7:04 PM

Retention Policy: Mailbox Items Delete (1 Year) Expires: 6/13/2018

Hi Dr. Rasmussen—

The patient's outreach score is based on the open opportunities the patient has, which could also include their severity. The higher the score the more need there should be to get the patient in. Sometimes patients could have even just come in, but if all of their conditions were not reviewed they will still have a high score. It does include gaps in care such as mammography and colorectal screening, so the more open quality gaps the higher the score.

We are unable to take hospice patients off of the list, unfortunately. They keep them on the list for cases that the patient may come off of hospice, or if they are still coming to the clinic for care. I wish we could remove patients of the list in cases like this, but there is not a way to do so.

Sarah

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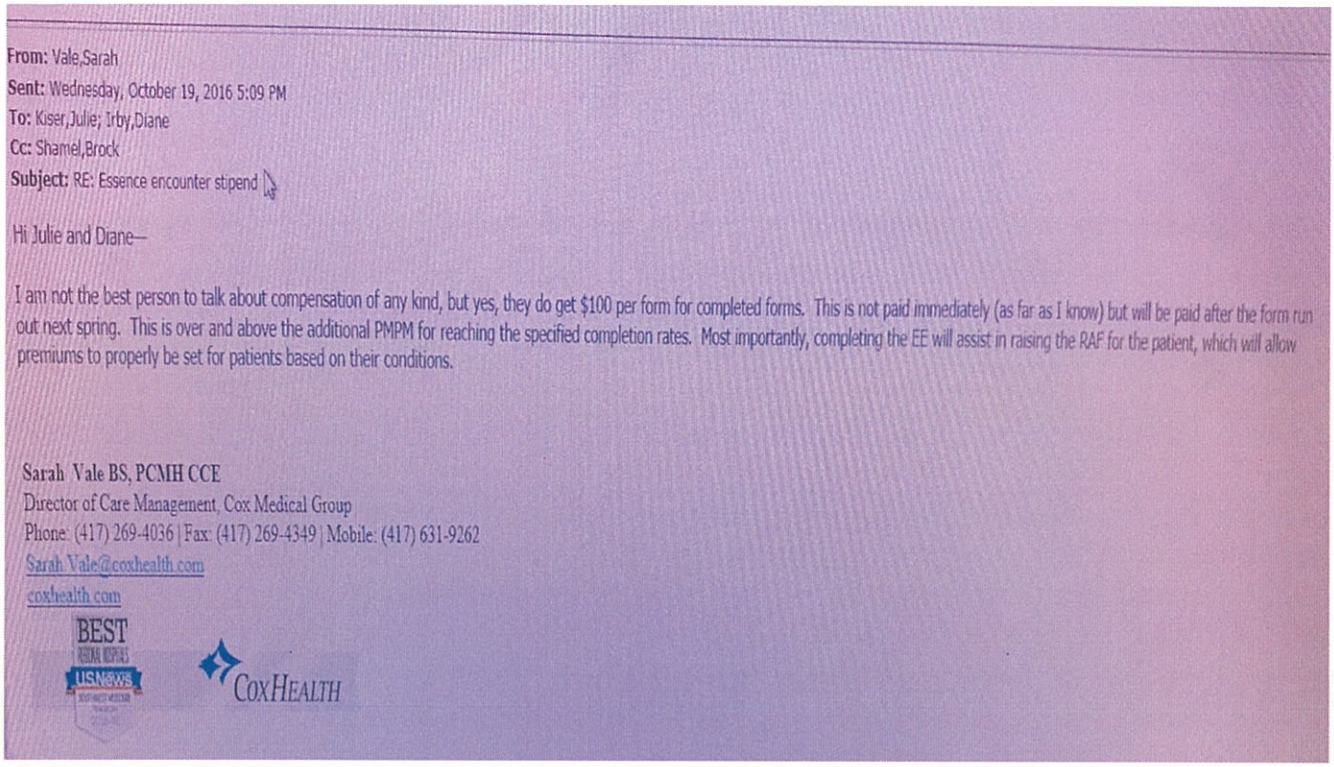
21. Essence, using Lumeris' software and data compilation identify alleged "high-risk members" that have "opportunities to improve documentation, coding, and/or coordination of care." These metrics have absolutely nothing to do with quality healthcare and everything to do with excessively billing Medicare. This is simply upcoding.

22. As the response goes on to provide, these missed "opportunities" are given a weighted score. The rationale for this weighted score is that, per the CMS formula, an MA plan can receive a higher capitation rate on a patient if it can show certain conditions are "linked." An example of this would retinal neuropathy in patients that have diabetes. Once again, this does not improve the patients care at all, it only makes more money for the defendants.

23. Shortly after beginning its program, Cox, Essence, and Lumeris made sure that retinal scanners were installed at Cox locations so that patients with diabetes could be scanned to "link" these issues and increase the capitation rate for that patient. This "screening" was done regardless of whether the patient was under the care of an ophthalmologist and even if the patient had already had a retinal scan performed during the year.

24. In addition to artificially inflating the RAF to receive a higher capitation rate for each patient, there was an individual incentive for the employees of Cox:



From: Vale,Sarah
Sent: Wednesday, October 19, 2016 5:09 PM
To: Kiser,Julie; Irby,Diane
Cc: Shamel,Brock
Subject: RE: Essence encounter stipend

Hi Julie and Diane--

I am not the best person to talk about compensation of any kind, but yes, they do get $100 per form for completed forms. This is not paid immediately (as far as I know) but will be paid after the form run out next spring. This is over and above the additional PMPM for reaching the specified completion rates. Most importantly, completing the EE will assist in raising the RAF for the patient, which will allow premiums to properly be set for patients based on their conditions.

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25. Essence, Lumeris, and Cox were providing a paid kick-back incentive to Cox employees based on "Enhanced Encounter." The purpose of this is also clearly spelled out in this communication: inflate the RAF score for each patient to get a higher capitation rate so that premiums would "properly be set."

26. Retinal scanners were not the only "opportunity" to link diseases and receive a higher RAF score, thereby increasing the capitation rate for a patient. In December of 2015 a "confidential" statement was released by Cox to its staff, to essentially upcode any elderly person with peripheral vascular disease ("PVD"):

CoxHealth Network

December 2015

Julia Flax, MD FAAFP

Medical Director, CoxHealth Network

Monthly Education Memo – Peripheral Vascular Disease (PVD)

When reviewing the latest Hierarchical Condition Categories (HCC) Prevalence Report from CoxHealth MedicarePlus (CHMP), there is a conspicuous difference in the prevalence of documented PVD in our CHMP population versus the Market. The chart below shows the prevalence of this HCC for FDC and Regional vs. the Market (includes St. Louis and Columbia).

HCC	1 — Market	2 — COX_FDC
V22: HCC 108: Vascular Disease	30.7%	7.8%
HCC	**1 — Market**	**2 — COX_RGNL**
V22: HCC 108: Vascular Disease	30.7%	6.5%

The good news is there is a great opportunity to not only assess our patients for PVD, but to document the diagnosis accurately if they meet the criteria. It is well documented that undiagnosed PVD is common. In a study of almost 7,000 primary care patients who were 70 years or older, or 50 to 69 years with risk factors for atherosclerosis, PVD was identified in 29% (1). Also, about half of all patients with PVD are asymptomatic.

Of note, the USPSTF recommends against routine screening using the ABI to screen asymptomatic patients for PVD (Grade: D recommendation). The ACCF/AHA and ADA recommend screening for PVD in asymptomatic patients who have risk factors that increase the likelihood of finding lower extremity PVD.

Table 1. Individuals at Risk for Lower Extremity PAD

• Age less than 50 years, with diabetes and one other atherosclerosis risk factor (smoking, dyslipidemia, hypertension, or hyperhomocysteinemia)
• Age 50-69 years and history of smoking or diabetes
• Age 70 years and older
• Leg symptoms with exertion (suggestive of claudication) or ischemic rest pain
• Abnormal lower extremity pulse examination
• Known atherosclerotic coronary, carotid, or renal artery disease
Adapted from: Rooke TW, Hirsch AT, Misra S, et al. 2011 ACCF/AHA Focused Update of the Guideline for the Management of Patients With Peripheral Artery Disease (updating the 2005 guideline): a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol.* 2011;58:2020-45.

Coding guidelines are included below. Essence should be sending out laminated ICD-10 Coding Reference Sheets to your clinic next week.

Coding is driven by whether the condition is related to atherosclerosis and/or diabetes and whether there are complications present (e.g., ulcers). Multiple codes may be required (you may have to choose one from List A and one from List B).

Simple, Uncomplicated PVD not related to Diabetes

70.209	Unsp atherosclerosis of native arteries of extremities, unsp extremity
I70.219	Atherosclerosis of the extremities with intermittent claudication, unsp extremity
I70.229	Atherosclerosis of native arteries of extremities with rest pain, unsp extremity
I73.9	Peripheral vascular disease unsp

Complicated PVD not related to Diabetes

List A

I70.25	Atherosclerosis of native arteries of other extremities with rest pain
I70.269	Atherosclerosis of native arteries of extremities with gangrene, unsp extremity

List B

L97.909	Non-pressure chronic ulcer of unsp part of unsp lower leg with unsp severity
L97.109	Non-pressure chronic ulcer of unsp thigh with unsp severity
L97.209	Non-pressure chronic ulcer of unsp calf with unsp severity
L97.309	Non-pressure chronic ulcer of unsp ankle with unsp severity
L97.409	Non-pressure chronic ulcer of unsp heel and midfoot with unsp severity
L97.509	Non-pressure chronic ulcer of other part of unsp foot with unsp severity
L97.809	Non-pressure chronic ulcer of other part of unsp lower leg with unsp severity
L98.429	Non-pressure chronic ulcer of back with unsp severity
L98.499	Non-pressure chronic ulcer of skin of other sites with unsp severity

Diabetes-related PVD that is not complicated by Ulceration

List A

I79.8	Other disorders of arteries, arterioles and capillaries in disease classified elsewhere
I96	Gangrene, not elsewhere classified

List B

E11.51	Type 2 DM with diabetic peripheral angiopathy without gangrene
E11.51	Type 2 DM with diabetic peripheral angiopathy without gangrene

Diabetes-related Ulcers

List A

E11.69	Type 2 DM with other specified complications
E11.69	Type 2 DM with other specified complications

List B

L97.909	Non-pressure chronic ulcer of unsp part of unsp lower leg with unsp severity
L97.109	Non-pressure chronic ulcer of unsp thigh with unsp severity
L97.209	Non-pressure chronic ulcer of unsp calf with unsp severity
L97.309	Non-pressure chronic ulcer of unsp ankle with unsp severity
L97.409	Non-pressure chronic ulcer of unsp heel and midfoot with unsp severity
L97.509	Non-pressure chronic ulcer of other part of unsp foot with unsp severity
L97.809	Non-pressure chronic ulcer of other part of unsp lower leg with unsp severity
L98.429	Non-pressure chronic ulcer of back with unsp severity
L98.499	Non-pressure chronic ulcer of skin of other sites with unsp severity

More information can be found on the Lumeris website in the Content Library – Clinical Education Documents.

27. The push behind this document, which originated from Lumeris, is clear: PVD is an easy way to increase the RAF score of a patient, it can be linked with other diseases to further increase the RAF score, and the capitation rate will further increase.

28. Cox's Confidential Statement recognizes that the medical literature strictly recommends against routine screening for asymptomatic PVD. Nevertheless, in an effort to overbill and push up RAF scores, Cox is pushing physicians to ignore medical literature, and instead, routinely screen for PVD in asymptomatic patients. A practice that is not medically necessary or warranted. The only purpose of this "screening" is to upcode and inflate the RAF score.

29. Since 2015, Cox, Essence, and Lumeris have continued these behaviors and have pushed out physicians and other health care staff that have refused to "play the game."

30. Indeed, Relator's contract was not renewed for this reason. Cox went on to retaliate, and set an example, by calling emergency departments relator has worked in for years and threatening

lawsuits if they continue to use Relator. Further, Cox stripped Relator of his medical privileges, despite his stellar reputation and lack of any complaints by his patients. Relation was fired because he reported this MedicarePlus fraud issues up the chain at Cox. Relator was also retaliated against for speaking up about the fraud.

31. Moreover, throughout the entire time Essence, Lumeris, and Cox have been systematically committing their fraud, Cox has continued to treat non-MA patients that have Medicare. Cox treats regular Medicare patients in a completely different manner: it does not instruct its physicians that they must see these patients for "Enhanced Encounters," nor is there review of these patients records by Essence and Lumeris to make sure that all coding has been "optimized." In short, Cox does not commit fraud with its normal Medicare patients when it must interact with CMS directly and provide itemized billing. Instead, Cox saves its fraud for its collaborations with Essence and Lumeris and the MA patients.

IV. JURISDICTION AND VENUE

32. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331 and 31 U.S.C. § 3732(a), which specifically confer jurisdiction on this Court for actions brought under 31 U.S.C. § 3730.

33. This Court has personal jurisdiction over Defendants Cox, Essence, Lumeris, and Essence Ground Holdings Corp., pursuant to 31 U.S.C. § 3732(a), as one all the Defendants have registered agents in, transact business in, and have committed acts related to the allegations in this Complaint in the Western District of Missouri. Defendants Cox, Essence, Lumeris, and Essence Ground Holdings Corp. all have a principal place of business in Missouri.

34. Venue is proper, pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391(b)-(c), as Defendants can be found in, reside in, and/or transact business in the Western District of Missouri, and

because many of the violations of 31 U.S.C. § 3729 discussed herein occurred within this judicial district.

V. THE FEDERAL FALSE CLAIMS ACT

35. The False Claims Act, as amended by the Fraud Enforcement and Recovery Act of 2009, Pub. L. No. 111-21, provides in pertinent part that:

> [A]ny person who (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (C) conspires to commit a violation of subparagraph (A), (B), . . . or (G); . . . or (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000 . . . plus 3 times the amount of damages which the Government sustains because of the act of that person.

31 U.S.C. § 3729(a)(1).

"A person may bring a civil action for a violation of section 3729 for the person and for the United States Government. The action shall be brought in the name of the Government." 31 U.S.C. § 3730(b)(1).

VI. THE MEDICARE ADVANTAGE PROGRAM

36. Medicare is a federally-funded health care program primarily serving people age 65 or older. Initially create in Title XVIII of the Social Security Act of 1965, Medicare now has four Parts, A through D. The two original components of Medicare are Part A, which covers inpatient hospital costs and related services, and Part B, which covers outpatient health care costs, such as physicians' fees. Medicare Part D was created by the Medicare Prescription Drug, Improvement, and Modernization Act established in 2003 ("MMA"), and covers prescription drugs.

37. Traditionally, Medicare operates on a fee-for-service basis, meaning that Medicare directly pays hospitals, physicians, and other health care providers for each service they provide to a Medicare beneficiary. Medicare beneficiaries are generally required to pay some portion of many of these services in the form of copayments, deductibles, coinsurance, or other set fees—these are often referred to, collectively, as "out of pocket expenses."

38. In 1997, Congress created Medicare Part C, which provides the same benefits to Medicare members, but does so based on a managed care model, rather than the traditional fee-for-service model. Under Part C, rather than pay providers directly, Medicare pays managed care plans—now known as MA plans—a fixed capitation rate (per member per month, or "PMPM") and those plans are responsible for paying providers for the services they provide to members of that specific MA plan.

39. MA plans must provide Medicare beneficiaries at least the same benefits they would have received under the traditional Medicare Parts A and B. Depending on the structure of the plan, MA plans may also provide additional benefits beyond what traditional Medicare would have covered, such as dental care, or cover some or all their members' out of pocket expenses associated with basic Medicare Parts A and B services or Part D prescription drugs.

A. CALCULATION OF MA PLAN CAPITATION RATES

40. The capitation rates Medicare pays to MA plans are determined based on a complicated process involving consideration of past and expected future medical expenses, the location of the plan's actual and expected members, the health status of those members, and whether the plan will include additional benefits. That process is summarized in Medicare regulations as follows:

> In short, under the bidding methodology each plan's bid for coverage of Part A and Part B benefits (i.e., its revenue requirements for offering original Medicare benefits) is compared to the plan benchmark (i.e., the upper limit of CMS' payment, developed from the county capitation rates in the local plan's service area or from

> the MA regional benchmarks for regional plans). The purpose of the bid-benchmark comparison is to determine whether the plan must offer supplemental benefits or must charge a basic beneficiary premium for A/B benefits.

Medicare Managed Care Manual (hereinafter "MMCM"), ch. 8, § 60.

41. In other words, it is a three-step process involving: 1) development of the MA plan's bid rate; 2) development of the CMS benchmark rate; and 3) comparison of those two rates to develop the basic capitation rate and determine whether any adjustments in the plan benefits or member premiums are required.

42. First, the MA plan develops a bid rate. This rate is the amount that the MA plan expects it will be required to pay to provide Medicare Parts A and B benefits to a hypothetical average member of the plan. This estimate must be based on either the MA plan's prior experience covering Medicare members, or on actuarially validated data analysis of expected costs. To represent an "average plan member, the bid rate must make adjustments to standardize the effect of expected geographic diversity (because some areas are more expensive than others) and the relative health status (i.e., the number and nature of chronic conditions) of the members whose claims experience provided the basis for the bid. The bid rate also includes an amount that the MA plan expects to spend on administrative costs, and a profit margin.

43. The mechanism for standardizing the bids by geographic area is known as the ISAR Factor. Medicare has determined that providing services to its members in certain counties tends to cost more than providing such services to members in other counties—either because the care is more expensive or because more care is required. Medicare has established tables which can be used to determine how expensive care is in one county versus another. When developing their bid rate, MA plans must use these tables to develop a rate that would be

required to provide care to a hypothetical member in a county where care for Medicare members costs an "average" amount.

44. The mechanism for standardizing the bid for individuals' health status is known as the "risk score" or CMS—Hierarchical Condition Category ("CMS-HCC"). It is an artificial score that CMS assigns to every beneficiary. CMS starts with a score of zero, and then adds points for the beneficiary's demographic condition (such as age and gender) and individual disease states (such as diabetes or heart failure). The average CMS—HCC score is one, with most Medicare beneficiaries having scores under three. Thus, someone with a risk score of two would be expected to need twice as much health care (in dollars) as someone with a score of one. The bid rate the MA plans develop must reflect the amount they will provide services to a hypothetical member with a risk score of one.

45. Second, the MA plan must calculate the appropriate Medicare benchmark rate. This rate is calculated using data provided by CMS about the amount that the Medicare program would spend to provide Parts A and B benefits to an average member in the geographic area covered by the MA plan's bid. This benchmark rate is based on the amount Medicare would pay for a member of standard health status (i.e., a risk factor of one). The benchmark rate also includes several other adjustments, including a bonus payment to incentivize health insurance companies to enter the MA market.

46. Third, the bid rate and the benchmark rate are compared to determine whether the MA plan must charge its members a premium, or, instead, if it must offer them enhanced benefits. If the bid rate is greater than the benchmark rate, Medicare will only pay the MA plan the benchmark rate per member per month ("PMPM"). That benchmark rate becomes the base capitation rate. The MA plan must then charge the beneficiaries who join its plan a monthly

premium to make up the shortfall between the bid rate and the base capitation rate. *See* MMCM, ch. 8, § 60.1.

47. If, on the other hand, the bid rate is less than the benchmark rate, then the bid rate becomes the start point for the calculation of the base capitation rate. The difference between the benchmark rate and the bid rate is then split between the plan members and the Medicare program. The first 25% of the difference is retained by the Medicare program as plan savings. The remaining 75% is returned to the MA plan, which must use the rebate to either provide enhanced benefits to its plan members or to cover the members' out of pocket expenses. In the end, then, in such situations, the base capitation rate equals the bid rate plus 75% of the difference between the bid rate and the benchmark rate.

48. Medicare does not, however, pay the plans the base capitation rate. Instead, when payments are made, the base capitation rate is adjusted for each member, to reflect his or her geographic ISAR score (based on the county where they live) and risk score (based on their health status).

49. Consequently, MA plans whose members live in relatively expensive counties will receive a higher actual capitation rate than another plan, even if both plans had the same base capitation rate. So too, MA plans with a high percentage of members with high risk factors will have a higher actual capitation rate than the MA plans with healthier, lower-risk members, even if their base capitation rate is the same.

50. MA plans must rebid their rates every year.

51. In the short term, MA plans stand to lose money if their members require more services (in dollars) than the capitation rate, because they are only paid in capitation rate, regardless of the actual cost of claims. Over the longer term, these effects tend to be mitigated because future years' rates are based on the present year's claims experience. Thus, plans that experience

unexpectedly high claims expense in year one, will generally see higher reimbursement in year two, and so forth.

B. MA Member Enrollment Rules Designed to Prevent Manipulation of Capitation Rates

52. CMS rules and the contracts between CMS and individual plans require MA plans to adhere to (and certify their adherence to) several requirements with respect to who enrolls in the plan, how they are enrolled, and what services will be provided to those members. Generally speaking, these rules require MA plans, such as Essence, to accept any Medicare beneficiary who is eligible to enroll, without regard for preexisting condition or prior claims experience. Consequently, plans are flatly prohibited from discriminating based on health in their enrollment or disenrollment activities, and cannot encourage members to disenroll from the plan for any reason.

53. In general, the use of risk status rather than claims experience encourages honest plans to manage their patients' health care more aggressively. Because CMS calculates risk adjustment by disease states, and not claims history, MA organizations will lose money on beneficiaries whose claims exceed their risk-adjusted Medicare premiums. On the other hand, MA organizations that successfully reduce the claims volume/cost of their sickest beneficiaries will make a profit on them, as CMS will continue to calculate the beneficiaries' premiums by their multiple disease states, and not by their low claims experience.

54. Conversely, if a plan were to act unscrupulously, it would do so by manipulating a patients' risk score. If a plan can partner with health care providers in such a way that the health care provider can link several diseases together or diagnose additional diseases, it would raise a patient's risk score so that the plan would then receive additional disbursement from CMS in

the future—this is regardless of the costs to treat that patient. This is regardless to the best interest of the patient. It is only meant to collect more money from Medicare.

C. CMS REQUIRES MA PLANS TO CERTIFY THE VALIDITY OF THEIR BID RATES AND SUPPORTING DATA TO PREVENT FRAUD

55. In recognition of the fact that the integrity of the capitation rates depends on the integrity of the actuarial information used by the MA plans in developing their bid rates, and to otherwise guard against fraud, CMS requires MA organizations to submit three separate attestations, each signed by the CEO or CFO (or their authorized, direct subordinate). These attestations are a condition that the MA plans must meet to be eligible to receive any capitation payments from CMS.

56. The first attestation, which the MA organization submits monthly, requires the MA organization to "attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization."

57. The second attestation, which is submitted annually, requires the MA Organization to attest that the risk adjustment data it submits annually to CMS is "accurate, complete, and truthful."

58. The third attestation is the MA Organization's certification "that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposal bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposal bid submission."

VII. FRAUD AGAINST THE UNITED STATES

59. Essence Group Holdings Corp., Essence, and Lumeris all boast that their leadership—many of whom have roles in more than one of these companies—long and distinguished. W. Michael Long is the Chairman and CEO of Essence Group Holdings Corp. and Lumeris; Art Glasgow is President and COO of Lumeris; Richard Jones is the CEO of Essence; James Starr is CFO of Essence; Debbie Zimmerman, M.D., is the Chief Medical Officer ("CMO") of Essence and Lumeris.

60. Mr. Long is "an entrepreneur in healthcare, financial services and energy, [and] has led teams that built Continuum, a multi-billion-dollar global leader in insurance software; Healtheon/WebMD, the largest consumer health information and transaction clearinghouse . . .; and NEOS, a solutions-oriented geosciences company that is leading the field in multi-measurement interpretation (of geo-datasets) and imaging of the earth's subsurface.

61. Mr. Glasgow's "experience includes senior executive roles with healthcare leaders such as Optum/UnitedHealth Group."

62. Mr. Jones was previously "National President of United Healthcare Medicare and Medicaid lines of business, President and Chief Executive Officer of Coventry Healthcare of the Midwest and Chief Financial Officer of Coventry Corporation."

63. Mr. Starr was previously "the Chief Financial Officer of National Segments and Products at Aetna, providing financial leadership to Aetna's national accounts, state and local governments, Medicaid and global benefits businesses."

64. Ms. Zimmerman "has a long and distinguished history of medical leadership at health plans such as Cigna, Group Health plan and Health Partners of the Midwest. Before joining Essence

Healthcare, she served as Chief Medical Officer of Mercy Health Plans, a provider-sponsored plan owned by Sisters of Mercy."

65. Other than Mr. Long, whom is a self-described entrepreneur in "healthcare, financial services and energy" and has no previous experience in administering a MA plan, each member of the executive leadership at Essence Group Holdings Corp., Essence, and Lumeris came from an insurance company that is currently under investigation for CMS fraud involving MA plans or has already been found civilly liable for CMS fraud involving MA plans.

66. UnitedHealth was sued by a whistleblower in 2011. The suit alleged that UnitedHealth's MA plan was attempting to inflate the risk score numbers of its members to increase revenues by as much as $100 Million. The Justice Department conducted a 5-year investigation that substantiated these claims.

67. Aetna and Cigna are both currently under investigation by the Justice Department for the same conduct as that of UnitedHealth.

68. On May 19, 2017 two Mercy Hospitals agreed to pay $34 Million in civil penalties to settle claims that it fraudulently billed Medicare.

69. The executive leaders of Essence Group Holdings Corp., Essence, and Lumeris have used their prior experience, it seems, to perpetrate additional fraud on CMS. Using the same practices as multiple of their previous employers have already been investigated for or civilly sued over, their current companies have continued the habits they previously learned elsewhere.

70. In addition to the fraud of Essence Group Holdings Corp., Essence, and Lumeris, the executive administrative staff of Cox is complicit in—and truly the lynchpin in this operation. For this fraud to work, Cox must bring patients in for Enhanced Encounters ("EE"). These EE's have nothing to do with providing actual health care services, rather they are an opportunity to

interview patients—most of who already have a long relationship with their physician for the only purpose of —increasing their RAF scores. This is done systematically and with "guidance" and "feedback" from Lumeris. In fact, this information is stored on a separate system requiring a separate log-in by physicians and Cox staff. This system is known as "ADSP."

71. The ADSP system provides healthcare providers with "critiques" of their coding so that an RAF score can be further "improved." This process is continued multiple times between Cox, Essence, and Lumeris staff to maximize a patient's RAF score.

72. Importantly this process began as soon as Essence and Lumeris developed and planned to implement the MA plan at Cox. Physicians were required to attend "training" that would help them identify "opportunities." As seen in the attached physician email notes, not only the tone but the content of this "training" came across as unethical. The patient that was identified as an "opportunity" was a patient that the physician knew the status of quite well. This was an elderly patient that, on paper, might look like a high-risk patient but that required very little treatment, in reality. Essence and Lumeris' message was clear: this patient is ideal because we can artificially inflate his RAF score, easily, and he will not actually cost that much in terms of services provided to the patient.

73. Cox pushed Relator to order EE's on patients where they were totally unnecessary. Indeed, Cox tried to force Relator to conduct EE's on hospice patients.

74. This message was repeated both audibly and implicitly in every interaction that Essence and Lumeris staff had with Cox staff. Lumeris would use it's "highly innovative software" to identify which patients Cox needed to call in for an EE and then, after that patient had been

seen would force the Cox physicians to upcode for that patient in order to get the highest RAF score possible.

75. This was further identified in Lumeris' communication to Cox staff about Peripheral Vascular Disease or PVD. The December 2015 internal Memo, shown above, from Julie Flax, clearly identifies to Cox staff that an "opportunity" was being missed by Cox in not properly coding PVD. The undertone here is clear yet again—this is an easy way to code patients to make them look sicker than they are thereby increasing their RAF score.

76. On top of this, Cox employees were given a "kickback" or inducement to comply with Essence and Lumeris' coding "recommendations." Cox employees would be given $100 for each EE form that was completed. This amounted to hundreds of thousands of dollars being given as an inducement to Cox employees, by Essence and Lumeris, to defraud CMS by artificially increase RAF scores.

77. Whenever employees opted not to "play the game" with this "program" they were either forced out—such as relator when he was told his contract with Cox would not be renewed and a non-compete would be enforced against him—or they resigned in order not to be complicit in a fraud on CMS and the United States taxpayers. Therefore, this fraud would be continually masked and allowed to be perpetrated against the United States.

78. Cox made it very clear with relator that he either "play the game" and help perpetuate the upcoding scheme or be terminated. Relator was terminated.

THE FRAUDULENT INSURANCE ACT

79. In 2017, the State of Missouri enacted the Fraudulent insurance act. "A person commits a 'fraudulent insurance act' if such a person knowingly presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported

insurer, broker, or any agent thereof, any oral or written statement including computer generated documents as part of, or in support of, . . . a claim for payment or other benefit pursuant to an insurance policy for . . . personal insurance, which such person knows to contain materially false information concerning any fact material thereto or if such person conceals, for the purpose of misleading another, information concerning any fact material thereto." Section 375.991.2.

80. Importantly, § 375.991.3 provides, "A 'fraudulent insurance act' shall also include but not be limited to knowingly filing false insurance claims with an insurer, health services corporation, or health maintenance organization by engaging in any one or more of the following false billing practices:

(1) "Unbundling", an insurance claim by claiming a number of medical procedures were performed instead of a single comprehensive procedure;

(2) "Upcoding", an insurance claim by claiming that a more serious or extensive procedure was performed than was actually performed;

(3) "Exploding", an insurance claim by claiming a series of tests was performed on a single sample of blood, urine, or other bodily fluid, when actually the series of tests was part of one battery of tests; or

(4) "Duplicating", a medical, hospital or rehabilitative insurance claim made by a health care provider by resubmitting the claim through another health care provider in which the original health care provider has an ownership interest.

81. This statute was specifically designed to provide a punitive means through which the State of Missouri Could seek out and stop the type of "unbundling," "upcoding," "exploding," and "duplicating" in which Essence, Lumeris, and Cox are engaged.

82. The State of Missouri even goes so far as to provide additional criminal punishments in its statutory scheme, *see* § 375.991.6, in addition to providing for restitution. *See* § 375.991.7.

COUNT I

SUBSTANTIVE VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT 31 U.S.C. §§ 3729(A)(1)(A)-(C), (A)(1)(G) AND 3732(B)

83. Relator realleges and incorporates by reference the preceding allegations of this Complaint.

84. This is a claim for treble damages and forfeitures under the Federal False Claims Act, 31 U.S.C. §§ 3729-33, as amended.

85. Through the acts described above, defendants Essence Group Holdings Corp., Essence, Lumeris, and Cox, their agents, employees, and co-conspirators, knowingly presented, or caused to be presented, to the United States false and fraudulent claims, and knowingly failed to disclose material facts, in order to obtain payment or approval from the United States and its contractors, grantees, and other recipients of its funds.

86. Through the acts described above, Defendants Essence Group Holdings Corp., Essence, Lumeris, and Cox, their agents, employees, and co-conspirators, knowingly made, used, and caused to be made and used false records and statements, which also omitted material facts in order to induce the United States to approve and pay false and fraudulent claims.

87. Through the acts described above, Defendants Essence Group Holdings Corp., Essence, Lumeris, and Cox, their agents, employees, and co-conspirators, knowingly made, used, and caused to be made and used false records and statements material to an obligation to pay and transmit money to the United States, and knowingly concealed and improperly avoided and decreased an obligation to pay and transmit money to the United States.

88. The United States, unaware of the falsity of the records, statements, and claims made and submitted by Defendants Essence Group Holdings Corp., Essence, Lumeris, and Cox, their

agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

89. Because of the payment made by the United States, as a result of the Defendants' fraud, the United States has suffered millions of dollars in damages and continues to be damaged.

COUNT II

90. Relator realleges and incorporates by reference the preceding allegations of this Complaint.

91. This is a claim for restitution on behalf of Charles Rasmussen, DO for the United States of America and for punitive damages against defendants Essence Group Holdings Corp., Essence, Lumeris, and Cox.

92. Through the acts described above, defendants Essence Group Holdings Corp., Essence, Lumeris, and Cox, their agents, employees, and co-conspirators, committed numerous fraudulent insurance acts in that they knowingly filed false insurance claims with CMS by engaging in unbundling, upcoding, exploding, and/or duplicating.

93. Through the acts described above, Defendants Essence Group Holdings Corp., Essence, Lumeris, and Cox, their agents, employees, and co-conspirators, knowingly made, used, and caused to be made and used false records and statements, which also omitted material facts in order to induce CMS to approve and pay false and fraudulent claims, in violation of Missouri law.

94. Through the acts described above, Defendants Essence Group Holdings Corp., Essence, Lumeris, and Cox, their agents, employees, and co-conspirators, knowingly made, used, and caused to be made and used false records and statements material to an obligation to pay and transmit money to CMS, and knowingly concealed and improperly avoided and decreased an obligation to pay and transmit money to CMS, in violation of Missouri law.

95. CMS, unaware of the falsity of the records, statements, and claims made and submitted by Defendants Essence Group Holdings Corp., Essence, Lumeris, and Cox, their agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

96. Because of the payment made by CMS, as a result of the Defendants' fraud, Defendants' have committed numerous violations of Missouri law and have done so it a fraudulent manner justifying compensatory and punitive damages.

PRAYER

WHEREFORE, *qui tam* plaintiff Dr. Charles Rasmussen, D.O., prayers for judgments against the Defendants Essence Group Holdings Corp., Essence, Lumeris, and Cox as follows:

1. That Defendants Essence Group Holdings Corp., Essence, Lumeris, and Cox cease and desist from violating 31 U.S.C. §§ 3729-33 and § 375.991-.994, RSMo 2017;
2. That the Court enter judgment against Defendants Essence Group Holdings Corp., Essence, Lumeris, and Cox in an amount equal to three times the amount of damages the United States has sustained as a result of Defendants Essence Group Holdings Corp., Essence, Lumeris, and Cox's actions in violation of the Federal False Claims Act, as well as a civil penalty of $10,000 for each violation of 31 U.S.C. § 3729;
3. That the Court enter an award of compensatory on behalf of Charles Rasmussen, DO for the United States of America and punitive damages in such an amount that would prove as a deterrent to other entities seeking to commit similar violations of the law;
4. That Relator be awarded the maximum amount allowed pursuant to 31 U.S.C. § 3730(d) of the Federal False Claims Act;
5. That Relator be awarded all costs of this action, including attorneys' fees and expenses; and

6. That the United States and Relator receive all such other relief as the Court deems just and proper.

JURY DEMAND

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Relator hereby demands trial by jury.

Respectfully Submitted,

STRONG-GARNER-BAUER, P.C.

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